Medical Statement for Students with Allergies or Chronic Illness Who Require Special Dietary Accommodations/Awareness.

St. John Paul II Catholic Schools

Student's Name_____ Date of Birth_____

Parent/Guardian_____

Cell Phone_____ Work Phone_____

JPII Catholic Schools will assist with food accommodations as able for this student **only when provided with the physician's statement specifying the reason for the accommodations.*

Does this student have a special dietary need? ☐ YES ☐ NO

Does this dietary restriction result in anaphylaxis? ☐ YES ☐ NO

***For anaphylactic (life threatening) food allergies please have your physician complete the Healthcare Provider Anaphylaxis Action Plan. Forms are located on the JPII website under the parent section**.

Please check which dietary modification this student requires:

____ Lactose Intolerance

____ Celiac Disease (gluten free)

____ Other _____

Describe what affects ingestion of this food will have on the student: _____

_____

Actions to be taken if child ingests these foods: _____

_____

Other comments: _____

_____

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider name printed: _____

Parent signature: _____ Date: _____